



**American College of Physicians
Statement for the Record
House Committee on Small Business**

The President's Budget and Medicare: How Will Small Providers be Impacted?"

March 18, 2009

Thank you, Chairwoman Velazquez and Ranking Member Graves for allowing me to share the American College of Physicians (ACP's) views regarding the President's Health Care Budget for Fiscal Year 2010.

I am Jeffrey P. Harris, MD, FACP, the President of the American College of Physicians, a general internist for three decades, who worked as a Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 40,000 people. I am pleased to be able to represent the College today at this hearing.

The American College of Physicians is the largest medical specialty society in the United States, representing 126,000 internal medicine physicians and medical students. Approximately 50 percent of our members involved in direct patient care after training are in practices of five or fewer physicians and 20 percent of these physicians are in solo practices. These practices are medicine's small business so ACP appreciates the opportunity to deliver its perspective to this committee on the President's health care budget for fiscal year 2010.

Smaller physician practices are an essential part of the system of care in the United States. A report describing ambulatory care visits provided in physician offices states that ambulatory medical care is the largest and most widely used segment of the health care system, with over 900 million visits in 2006. The report found that approximately 82 percent of office visits are furnished in practices with five or fewer physicians. While about 31 percent of office visits are provided in the solo practices, 46 percent are furnished by single-specialty groups with 22 percent provided in multi-specialty practices.

We are pleased that the President's budget provides a down payment on health care reform and provides an opportunity for Congress to address the issues of physician payment reform, expanding access to health care coverage, the primary care workforce shortage, health information technology, and comparative effectiveness.

Funding for Physician Payment Reforms

Accounting for the Costs of Preventing Medicare Physician Pay Cuts

We are grateful that the President's budget recognizes a shortfall in the current Medicare payment formula and intends to dedicate funding to account for "additional expected Medicare payments to physicians over the next 10 years."

Over the past several years, one of the College's main priorities has been urging Congress to reform Medicare's flawed physician payment formula known as the Sustainable Growth Rate, or SGR. This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices. Although Congress has acted to avert scheduled Medicare payment cuts in the last several years, it has not acted to permanently fix the flawed payment formula. Unless Congress acts to provide the funding necessary to fix this flawed Medicare payment formula, physicians will face continued uncertainty over Medicare reimbursement rates in the future.

Dr. Peter Orszag, who heads the White House's Office of Management and Budget, had this to say in testimony before the House Budget Committee:

"Our Budget includes the Administration's best estimate of future SGR relief given the agreed-to fixes for Medicare physician reimbursement in past years. As a result, projected deficits are about \$400 billion higher over the next ten years than they would otherwise be. In contrast, past budgets accounted for no SGR relief in any years. (Although our Budget baseline reflects our best estimate of future SGR relief given past policy actions on SGR, as discussed below we are not asserting that this should be the future policy and we recognize that we need to move toward a system in which doctors face stronger incentives for providing high-quality care rather than simply more care.)"

Accounting for funds needed to reform the flawed sustainable growth rate (SGR) payment formula could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts.

Since 2002, Congress has stepped in just about every year to enact temporary "patches" to stop the SGR cut, but has not come up with a permanent replacement. Rather than accounting for the difference between the lower amount mandated by the SGR, and the higher amount paid out under the patch, Congress assumed that the higher spending will be made up with even an even deeper SGR pay cut the following year.

This is why the "patch" for an estimated 5 percent SGR cut in 2008 resulted in a scheduled 10.5 percent SGR cut in 2009. And why the patch for the 10.5 percent SGR cut in 2009 balloons to a scheduled 21 percent cut in 2010.

No one really expects, though, that the 21 percent cut will go into effect. As in past years, Congress is expected to pass legislation to prevent the cut. This time, though, Congress has an opportunity to do it in a way that accurately accounts for the costs rather than masking them.

Since this is a hearing of the Committee on Small Business, the following analogy may help illustrate the problem. Imagine you worked for a small business, and imagine that your boss told you that your wages would be cut by 10 percent this year.

Later, your boss announces that your company will not cut your wages, but that the only way the company can afford to stop the 10 percent cut will be to pretend to reduce your wages by 20 percent the following year. She tells you not to worry, though: they will just do the same thing next year - prevent the 20 percent cut by pretending that the cost will be made up by cutting your wages by 40 percent the following year. She adds, though, that the company has no intention of ever allowing the 40 percent cut to happen. They just have to pretend they will so their accountants will allow them to stop the immediate pay cut.

No small business would actual run its payroll budget this way. Yet this is how Washington has handled costs associated with stopping the SGR.

President Obama's budget is a marked departure from past practices, because it acknowledges what we all know to be true, which is that preventing pay cuts to doctors will require that Medicare baseline spending be increased accordingly. To be clear, the College understands why Congress and the previous administration resorted to paying for temporary SGR fixes by assuming cuts in later years. The reason was to eliminate the necessity of finding hundreds of billions of budget offsets under pay-as-you go rules.

It is not that our physician-members and their patients do not recognize and appreciate the actions that Congress has taken in the past to stop the SGR cuts. It is just each time this has been done, the accumulated cost of finding a long-term solution has increased.

ACP recognizes that some "deficit hawks" may be troubled by President Obama's proposal to acknowledge the true costs of preventing deep and sudden cuts in payments to physicians. ACP understands this concern, but also believes that accurate budgeting is a pre-requisite to fiscal responsibility. Masking the costs of stopping the SGR cuts does not make the cost go away. It just hides it, making the true cost of the next "patch" even greater, creating an insurmountable barrier to a long-term solution.

ACP urges committee members to make a formal request to your colleagues on the House Budget Committee and to the leadership of the House to incorporate into the budget resolution *an accurate accounting of the true costs over the next 10 years of providing physicians with positive updates* in lieu of the SGR pay cuts. The budget resolution should further stipulate that this increase in Medicare baseline spending assumptions would not be subjected to pay-as-you go offsets.

Once the true costs are accounted for in the budget, Congress and the administration should enact a long-term solution that will permanently eliminate the SGR as a factor in updating payments for physicians' services. Instead, payment updates should provide predictable increases based on the costs to practices of providing care to Medicare patients. This is especially important for physicians in smaller practices, where Medicare payments are not keeping pace with their overhead costs.

Reform of Medicare Payments to Support Primary Care

The Institute of Medicine recently reported that 16,261 additional primary care physicians are now needed to meet the demand in currently underserved areas. Two recent studies project that the shortages of primary care physicians for adults will grow to more than 40,000.

The primary care shortage is escalating at a time when the need for primary care physicians is greater than ever. Our aging population is further increasing the demand for general internists and family physicians. In addition, increasing numbers of patients with multiple chronic diseases is also increasing the demand for primary care.

Even though decades of research tells us that primary care is the best medicine for better health care and lower costs, the current U.S. health care system fails to support policies and payment models to help primary care survive and grow. More than 100 studies, referenced in ACP's recent paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*, demonstrate that primary care is consistently associated with better outcomes and lower costs of care. Congress should enact Medicare payment reform so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings expectations. This will require immediate increases in Medicare fee-for-service payments to primary care physicians, starting in the current calendar year, followed by continued annual increases in payments for primary care physicians.

Medical students and young physicians should make career decisions based on their interests and skills, instead of being influenced to a great extent by differences in earnings expectations associated with each specialty. Yet there is extensive evidence that choice of specialty is greatly influenced by the under-valuation of primary care by Medicare and other payers compared to other specialties.

- A 2007 survey of the perception of fourth-year medical students pertaining to internal medicine, compared to other specialties they had chosen or considered, is telling. Respondents perceived internal medicine as having lower income potential while requiring more paperwork and a greater breadth of knowledge.
- A recent study compared residency position fill-rates with average starting salaries by specialty and found that U.S. medical students tend to choose more highly compensated specialties. For example, the lowest average starting salary of any specialty was family medicine (\$185,740) while the highest average

starting salaries were in radiology and orthopedic surgery (\$414,875 and \$436,481). In 2007, only 42.1 percent of first-year family medicine residency positions were filled by U.S. medical school graduates compared to 88.7 percent in radiology and 93.8 percent in orthopedic surgery.

- A 2008 analysis found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates.
- One author suggests that achieving a national goal of 50 percent of clinicians practicing in primary care will require “improving the payment gap between primary care physicians and specialists such that the generalist-to-population ratio increases.”

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. [ACP analysis based on data from two sources: Medical Group Management Association--2008 and Merritt Hawkins – 2008 Review of Physician and CRNA Recruiting Incentives – Top Twenty Searches]. This compensation gap is contributing to a growing shortage of primary care physicians, and particularly primary care physicians in smaller practices.

To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties.

- The level of payment for services provided principally by primary care physicians must be increased to be competitive with other specialty and practice choices, taking into account any additional years of training associated with specialty training programs.
- A target goal for raising primary care reimbursement to make it competitive with other specialty and practice options should be established by the federal government based on, in part, an analysis of the current marketplace and the price sensitivity of physicians with respect to projected income and choice of specialty.

For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal. Achieving 100 percent parity would require annual increases of 12-13 percent over five years.

Such market competitiveness targets could also be adjusted to take into account expansion of existing programs and development of new ones to reduce or eliminate student debt for physicians selecting primary care careers, so that the combined differential between debt and expected earnings is comparable to other specialty choices.

Other countries have made investments to increase pay to primary care physicians to make them competitive with other specialties, and have found such investments to be

effective in attracting more physicians to primary care. The new contract for the English National Health Service “helped increase recruitment into primary care and was advantageous to family physicians, whose incomes increased 58 percent between 2002-03 and 2005-06.

The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare pay a bonus for primary care services furnished by physicians whose practices focus on primary care. While MedPAC would defer to Congress to determine the precise bonus payment amount, it identifies the 10 percent bonus currently paid for services furnished in health professional shortage areas and the 5 percent bonus that was previously provided for services in areas with a low physician-to-population ratio as a starting point for discussion. MedPAC initially made this recommendation in June 2008—when it devoted an entire chapter in its Report to Congress to “Promoting the Use of Primary Care”—and reiterated it in its March 2009 Report to Congress “to emphasize its importance.” The MedPAC rationale for the bonus payment is that primary care services are undervalued and that physicians focused on furnishing primary care services cannot increase the frequency with which they furnish these services—as can be more readily done for tests and procedures—to increase their revenue.

Redefine Budget Neutrality Rules Relating to Increased Payments for Primary Care

ACP appreciates the MedPAC attention to the payment disparity problem. The MedPAC recommendation that the bonus payment not increase the overall amount that Medicare spends on physician services, however, deviates from the College’s position. The College believes that the funding should not be restricted to budget neutral adjustments in the Medicare physician fee schedule and instead should take into consideration the impact of primary care in reducing overall Medicare costs, including costs under Part A associated with reductions in preventable hospital, emergency room and intensive care unit visits associated with primary care.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

To illustrate how much can be saved by creating payment incentives for primary care, a recent study in *The American Journal of Medicine* found that “higher proportions of primary care physicians [in each metropolitan statistical area] were associated with significantly decreased utilization, with each 1 percent increase in the proportion of primary care physicians associated with decreased yearly utilization for an average size metropolitan statistical areas of 503 admissions, 2968 emergency department visits, and 512 surgeries.” (Kravet, et al, *Health Care Utilization and the Proportion of Primary Care Physicians*, *The American Journal of Medicine*, February 5, 2008).

It stands to reason, then, that Congress should allow for some of the aggregate savings from reduced utilization associated with primary care to be used to fund payment increases targeted to primary care.

It also is not clear whether MedPAC intends for the adjustment to be a one-time adjustment or one that is sustained and continued over several years until the market compensation gap between primary care and other specialties is closed. The College believes that a one-time adjustment, even if it is as high as 10 percent, will be insufficient to make primary care competitive with other specialties. In addition, the amount of the adjustment should not be left up to Congress to decide each year, but should instead be scheduled in advance so that annual compensation increases in increments until parity is reached with other specialties. Such predictability is needed to influence the career decisions of medical students and associates who are contemplating the current and future potential of primary care compensation, as well as to established primary care physicians who may be contemplating a career change or early retirement.

Funding for Programs to Support the Patient-Centered Medicare Home

The Patient-Centered Medical Home enjoys the support of a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement the demonstration currently being developed that focuses on practices that use advanced HIT. Other bills have been or are likely to be introduced that would direct additional Medicare medical home test projects.

Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payer PCMH tests, many involving multiple health plans, underway or being developed across the country.

Practices must demonstrate that they have the structure and capability to provide patient-centered care to be recognized as a PCMH. The most recently used PCMH recognition module classifies a qualifying practice as one of three medical home levels, each indicating a progressive level of capability. While practices must demonstrate capability beyond what is typical, they have some ability to reach the requisite PCMH recognition score in different ways. ACP is aware that government programs exist that address focused areas that are relevant to the PCMH. The current scope of work governing the Medicare Quality Improvement Organization (QIO) program involves 14 organizations focusing on improving transitions in care, e.g. inpatient to ambulatory setting, in certain geographic areas [cite QIO 9th SOW]. The Department of Health and Human Services maintains a program that facilitates the ability of physicians to provide language translation services to patients. The federal government should provide sufficient funding for programs to help smaller physician practices qualify as PCMHs.

In addition, the current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot.

The budget should also provide states with dedicated federal funding to implement PCMH demos for Medicaid, SCHIP, and all-payer programs.

The Commonwealth Fund's Commission on a High Performing Health Care System recently issued a report that advocates that the federal government "Strengthen and reinforce patient-centered primary care through enhanced payment of primary care services and changing the way we pay for primary care to encourage the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention." The report estimates that widespread implementation of the medical home model would reduce national health care expenditures by \$175 billion over ten years.

Budgeting for Comprehensive Health Care Reform

President Obama has proposed a \$634 billion fund for comprehensive health system reform.

The College strongly supports the concept of creating a dedicated source of funding for health reform, but we have not taken a position on the administration's specific proposals to pay for this fund. For instance, the fund would be paid for in part by targeted reductions in spending on specific programs funded by Medicare, including Medicare Advantage plans, hospitals with high rates of re-admissions, Medicare Part D drug pricing, and increasing the contributions of higher income beneficiaries to Part D. We agree that spending on Medicare needs to be carefully evaluated to determine if there are savings in certain areas that could be re-allocated to comprehensive health care reform, but recommend that Congress obtain more specifics on the Medicare savings proposed by the administration, seek input from the public and key stakeholders on such savings, and consider potential alternatives. The College does support the administration's goal, of leveling the playing field in Medicare payments to Medicare Advantage plans and traditional Medicare.

On March 9, ACP joined 29 other advocacy groups representing physicians, hospitals, consumers, patients, insurers, and many others in a joint letter to the House and Senate budget committees. The letter urges that the congressional budget resolution provide the resources needed to enact comprehensive health reform legislation. The letter makes the point that the Congressional Budget Office's current scoring rules do not recognize many of the savings to be achieved by a restructuring of the health care system:

"In our view, such legislation should include effective provisions to reduce costs by improving the quality and efficiency of health care and help ensure coverage for every American. Legislation of this kind will reduce the rate of growth of both

federal and private health care expenditures, and will thus improve the fiscal health of the nation. While the cost savings from improving the efficiency and quality of health care will be significant, many of the anticipated savings will be realized in the long term, and may thus not be evident in a ten year budget window. Moreover, CBO's current scoring conventions do not recognize many of the savings to be achieved by a restructuring of the health care system. We believe, therefore, that it would be reasonable to develop an approach for health care reform that reflects both the near-term exigencies and long-term savings of such extraordinary legislation. Requiring spending or revenue offsets for the entire cost of health reform within a ten year budget window, as required under a traditional pay-as-you-go rule, will significantly reduce the likelihood of enacting legislation to achieve essential reforms for long-term savings.”

Accordingly, the College urges committee members to recommend to your colleagues on the House Budget Committee and House leadership that the committee develop a more flexible approach to pay-as-you-go for health care reform that reaffirms the importance of offsets, but accommodates the need for significant short-term expenditures that will help set the health system on a path toward significant long-term savings and improvement in the long-run fiscal future of our country.

Other Budgetary Priorities

Health Information Technology

ACP appreciates the \$19 billion investment included in the Economic Recovery Act that will continue efforts to further the adoption and implementation of health information technology. We support the positive Medicare payment incentives for physicians who acquire health information technology and use it for meaningful purposes, like reporting on quality measures or using it to remind patients to get recommended preventive services. Starting in 2015, the legislation will subject physicians to Medicare payment cuts if they are “non-compliant.”

The College believes that it is imperative that the overall environment be hospitable to the purchase of certified EHRs before imposition of penalties that would reduce baseline payments to physicians not using certified systems beginning in 2015. While penalties will not adversely affect physicians for some time, small and/or rural practices, which are in the greatest need of assistance, stand to lose the most if penalties take effect before the barriers to their HIT adoption and use are addressed. The American Recovery and Reinvestment Act requires or sets in motion activities to create an environment in which EHRs that harness the potential of the technology—including the establishment of standards and processes—are commonly available. However, there is no guarantee that challenges will be met in the timeframe envisioned.

While Congress could pass legislation delaying payment penalties or otherwise amending the current law (and the current law does permit exemption from penalties for hardship, term yet-to-be defined, cases), it is prudent to identify goals, with associated time frames, that must be met and to establish a process by which penalties are reassessed when certain time frames fail to be met. Specific benchmarks that reflect the needed progress should include but not be limited to: certifying the sufficient availability of HIT at a cost that avoids imposing an unreasonable barrier; and certifying that technical capabilities, including functionality and interoperability, are applicable to small and/or rural practices, especially those that furnish primary care, to enable successful adoption and use. Imprudent HIT purchase in the face of impending penalties would be devastating to these practices.

ACP urges the House Committee on Small Business to exercise oversight of the HIT incentives program included in the American Recovery and Reinvestment Act Economic Recovery Act, and specifically, to hold HHS accountable for making sure that the overall environment is hospitable to the purchase of certified EHRs before penalties are imposed, especially on smaller practices that will face the greatest challenges to HIT adoption.

Comparative Effectiveness Research

ACP strongly supports the \$1.1 billion in additional funding included in this legislation to support research on the comparative effectiveness of different medical treatments. The Healthcare Effectiveness provisions included in the American Recovery and Reinvestment Act will build on the excellent, but limited and inadequately funded, comparative effectiveness activities currently being engaged in by the Agency for Health Research and Quality (AHRQ) and the National Institutes of Health. They are an excellent first step towards the future establishment of an adequately funded, independent, trusted, national entity to prioritize, sponsor and/or produce trusted research on the comparative effectiveness of healthcare services. They will create jobs associated with hiring more researchers and development of tools to effectively integrate comparative effectiveness research into clinical decision-making at the point of care, and will have an even greater and lasting benefit to the economy.

The Congressional Budget Office (CBO) estimates that providing \$100 million to comparative effectiveness in 2010 and allowing this to grow to \$400 million through 2019 would reduce total spending on health care in the U.S. by \$8 billion during 2010-2019. \$8 billion in health care savings will translate directly into lower health care costs for employer and employees. Funding of the research in the larger amounts should result in even greater savings.

Summary and Conclusions

Physicians in smaller practices have a tremendous stake in the decisions that Congress will make this year on the federal budget. Congress has an historic opportunity this year

to adopt a budget that will help physicians in smaller practices provide the best possible care to patients by:

- eliminating payment cuts from the SGR and accounting for the true costs associated with providing updates that reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions
- increasing Medicare payments to primary care physicians to make them competitive with other specialties and career choices
- modifying Medicare budget neutrality rules to allocate a portion of anticipated savings associated with primary care, such as from reduced preventable hospital and emergency room admissions, to fund increases in payments for primary care services
- funding programs to support and expand the Patient-Centered Medical Home
- creating a dedicated federal fund for comprehensive health care reform, while allowing for further analysis of the administration's proposals to pay for it, including consideration of potential alternatives
- developing a more flexible approach to pay-as-you-go rules in the context of health care reform, one that reaffirms the importance of offsets while accommodating the need for significant short-term expenditures that will help set the health care delivery system on a path toward significant long-term savings resulting in improvement in the fiscal future of our country over the long term
- continuing to fund a Medicare incentive program to provide positive incentives for physicians to acquire health information technology and to use it for meaningful purposes, but with oversight to assure that the overall environment is hospitable to the purchase of certified EHRs before penalties are imposed, especially with regard to smaller practices that face the greatest challenges to HIT adoption.
- increasing funding for research on comparative effectiveness to inform clinical decision-making

ACP appreciates the opportunity to share its views regarding the President's budget and outline the College's priorities for health reform. We remain committed to working with you and your colleagues in the Congress to pass legislation that will improve the quality and lower the costs of our health care system.